UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

QUANTITY OVERRIDE REQUEST

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Pharmacy NPI#:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR A LETTER OF MEDICAL NECESSITY TO 855-828-4992

Please use the Opioid Quantity Override Request for any opioid-containing agents

GENERAL CRITERIA:

- The name and strength of the drug requested
- Acknowledgement of the drug's specific quantity limit
- Detailed explanation of the reason for the quantity override request

INITIAL AUTHORIZATION: One year

RE-AUTHORIZATION: One year upon receipt of an updated letter of medical necessity